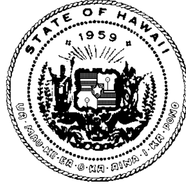
DAVID Y. IGE
GOVERNOR



PANKAJ BHANOT
DIRECTOR

CATHY BETTS
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

February 22, 2018

TO: The Honorable Representative Sylvia Luke, Chair
House Committee on Finance

FROM: Pankaj Bhanot, Director

SUBJECT: **HB 885 HD1 – RELATING TO DELAY IN PRIOR APPROVAL FOR MEDICAL SERVICES**

Hearing: Friday, February 23, 2018, 11:00 a.m.
Conference Room 308, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) offers comments with concerns.

PURPOSE: The purpose of the bill is to prohibit insurers from requiring preauthorization that cause undue delay in a patient's receipt of medical treatment or services; and clarify insurer and licensed health care provider liability for patient injuries caused by preauthorization delays.

Per federal Medicaid regulations, the Medicaid program has requirements that services provided are medically necessary. Thus Medicaid has requirements for utilization management such as prior authorizations. We need to ensure that services are provided at the right time, right setting etc., to ensure optimal care with the best health outcomes. Nearly 100 percent of Medicaid recipients are enrolled in a QUEST Integrated (QI) managed care plan. As part of the QI contracts, and in accordance with federally required language, there are specific provisions that outline timeframes in which a health plan must respond to a prior authorizations, to utilization management programs, as well as to access standards for emergent, urgent, and other care. MQD monitors and provides oversight of the QI plans' adherence to these requirements.

The proposed liability changes may lead to unintended adverse impact on both patient safety and on costs. For example, one concerning consequence may be on the rising opioid epidemic. Prior authorizations and other utilization management tools for the prescribing of opioids are one of the methods for ensuring that prescribers follow new guidelines for the prescribing of opioids. We also note that the American health care system is the most costly health care system in the world with only adequate health outcomes. There are also estimates that about 20 percent of all care is unnecessary. While it is essential that we analyze all the cost drivers for our health care delivery system, this bill will likely lead to increased costs, as fewer prior authorizations would be put in place.

Thank you for the opportunity to provide comments on this measure.

DAVID Y. IGE
GOVERNOR

DOUGLAS S. CHIN
LIEUTENANT GOVERNOR

STATE OF HAWAII
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DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
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CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON
FINANCE

TWENTY-NINTH LEGISLATURE
Regular Session of 2018

Friday, February 23, 2018
11:00 a.m.

TESTIMONY ON HOUSE BILL NO. 885, H.D. 1, RELATING TO DELAY IN PRIOR APPROVAL FOR MEDICAL SERVICES.

TO THE HONORABLE SYLVIA LUKE, CHAIR, AND MEMBERS OF THE COMMITTEE:

The Department of Commerce and Consumer Affairs ("Department") appreciates the opportunity to testify on H.B. 885, H.D.1, Relating to Delay in Prior Approval for Medical Services. My name is Gordon Ito, and I am the Insurance Commissioner for the Department's Insurance Division. The Department takes no position on this bill and offers the following comments.

The purpose of this bill is to prohibit health insurers from requiring preauthorization that causes undue delay in a patient's receipt of medical treatment or services. The bill also purports to grant civil immunity to a licensed health care provider for injury to a patient casued by undue delay in preauthorization, and impose civil liability on an insurer for any patient injury caused by undue delay in the receipt of medical treatment or services.

This bill would add new sections (preauthorization; undue delay; liability) to Hawaii Revised Statutes ("HRS") chapter 431 to apply to health insurers and HRS

chapter 432 to apply to mutual benefit societies, as well as amend section HRS 432D-23 to apply to health maintenance organizations.

Medical determinations are complex and not conducive to blanket regulation by HRS title 24. These medical decisions seek to balance patient safety, effectiveness, and medical appropriateness and are outside the purview of HRS title 24. The granting of immunity to health care providers for injuries and the imposition of liability on insurers regarding medical decisions are likewise outside the purview of HRS title 24.

Thank you for the opportunity to testify on this measure.

HAWAII MEDICAL ASSOCIATION
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www.hawaiimedicalassociation.org

TO:
COMMITTEE ON FINANCE
Rep. Sylvia Luke, Chair
Rep. Ty J.K. Cullen, Vice Chair

DATE: Friday, February 23, 2018
TIME: 11:00 A.M.
PLACE: Conference Room 308

FROM: Hawaii Medical Association
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Government and Community Relations

Re: HB 885

Position: SUPPORT

Hawaii Medical Association strongly supports this legislation.

If a doctor orders a necessary test, and that test is delayed or denied by an insurance plan, and that patient suffers as a result of this delay or deny, the physician should not be held liable for the patients injury as it pertains to the delay in treatment.

This bill is a common sense measure and should be enacted as soon as possible to ensure patient safety and encourage health plans approve appropriate care.

This bill has the following admirable goals:

1.) Prohibit insurers from requiring preauthorization that causes undue delay in a patient's receipt of medical treatment or services; and
2.) Clarify liability for patient injuries caused by preauthorization delays.

It is only fair that a licensed health care provider should be immune from civil liability for injury to a patient that was caused by undue delay in preauthorization of medical treatment services. The insurer should be civilly liable for any injury that occurs to a patient because of undue delay in medical treatment.

Thank you for the opportunity to provide testimony in strong support of this measure and thank you for hearing this important bill. This bill will help to make Hawaii a more viable place to practice medicine.

HMA OFFICERS
President – William Wong, Jr., MD President-Elect – Jerry Van Meter, MD Secretary – Thomas Kosasa, MD
Immediate Past President – Bernard Robinson, MD Treasurer – Elizabeth A. Ignacio, MD
Executive Director – Christopher Flanders, DO

February 23, 2018

The Honorable Sylvia Luke, Chair
The Honorable Ty J.K. Cullen, Vice Chair
House Committee on Finance

Re: HB 885, HD1 – Relating to the Delay in Prior Approval for Medical Services

Dear Chair Luke, Vice Chair Cullen, and Committee Members:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 885, HD1, which prohibits health insurance preauthorization requirements that cause undue delay in receipt of medical treatment or services and specifies that insurers, but not health care providers, are liable for civil damages caused by undue delays for preauthorization. HMSA opposes this Bill and offers the following comments.

HMSA and providers share the same goal – protecting the health and safety of people who trust us with their care. We work together to reach that goal but sometimes disagree on how to get there. While we work every day to balance the needs of our members, physicians, employer groups, and government partners, our first priority is always the need and safety of our members.

We are seriously concerned that HB 885, HD1 would encourage plans to minimize preauthorization requirements, resulting in potentially dangerous health consequences for members and increase costs to Hawaii's healthcare system. A preauthorization requirement is designed to (1) improve a patient's health and well-being by preventing overuse of medical services that could unintentionally cause harm, and (2) prevent wasteful services that people do not truly need.

Preauthorizations are required for a range of medical procedures, medications, and durable medical equipment. Most notably with public concern over rising drug costs, preauthorizations can help identify an appropriate generic medication in lieu of a more expensive brand named drug. Virtually every health plan, including Medicare and Medicaid, require preauthorizations for numerous services.

The Centers for Medicare & Medicaid Services (CMS), the National Committee for quality Assurance (NCQA), and the Health Services Advisory Group (HSAG), which oversees Medicaid in Hawaii, all have prior authorization guidelines and definitions on urgent versus non-urgent requests, specific turnaround times, and approval and denial processes. HMSA follows these guidelines and definitions.

HB 885, HD1 unfairly gives the provider immunity from civil liability for "injury to a patient that was caused by undue delay in preauthorizing medical treatment or services", and it holds the health plans solely liable. This provision does not account for situations under which the physician may have contributed to the delay during the preauthorization process. To hold the plan solely liable for any injury is unjust.

HB 885, HD1 would create an environment of uncertainty and confusion where plans ultimately may resist requiring preauthrizations just to avoid the negative legal consequences contemplated in this Bill. Furthermore, this measure generates more uncertainly with respect to its impact on preauthorizations required under Medicare and Medicaid.

We respectfully ask that the Committee defer HB 885, HD1. Thank you for the opportunity to testify.

Sincerely,

Pono Chong
Vice-President, Government Relations

TESTIMONY OF THE AMERICAN COUNCIL OF LIFE INSURERS
COMMENTING ON HOUSE BILL 885, HD 1, RELATING TO DELAY
IN PRIOR APPROVAL FOR MEDICAL SERVICES

February 23, 2018

Honorable Representative Sylvia Luke, Chair
Committee on Finance
State House of Representatives
Hawaii State Capitol, Conference Room 308
415 South Beretania Street
Honolulu, Hawaii 96813

Dear Chair Luke and Committee Members:

Thank you for the opportunity to comment on HB 885, HD 1, Relating to Delay in Prior Approval for Medical Services.

Our firm represents the American Council of Life Insurers ("ACLI"), a Washington, D.C., based trade association with approximately 290 member companies operating in the United States and abroad. ACLI advocates in state, federal, and international forums for public policy that supports the industry marketplace and the policyholders that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing 95 percent of industry assets, 93 percent of life insurance premiums, and 98 percent of annuity considerations in the United States. Two hundred twenty-one (221) ACLI member companies currently do business in the State of Hawaii; and they represent 96% of the life insurance premiums and 100% of the annuity considerations in this State.

HB 885, HD 1, seeks to amend Article 10A of Hawaii's Insurance Code, relating to Accident Health and Sickness insurance by adding a new Section to that Article that would prohibit *all insurers* issuing accident and health or sickness insurance policies, plans, contracts or agreements from requiring its preauthorization of medical services or treatments "so as to cause an undue delay" in the insured's receiving medical treatment or services. For violation, the insurer is made liable for the insured's injury caused by the undue delay in receiving medical treatment.

By its terms, however, *Article 10A of the Code (by reference to HRS §431:1-205) defines "accident and health or sickness insurance"* to include not only health and medical insurance but also ***disability income insurance***.

ACLI submits that these provisions are intended to apply only to health insurance – not disability income insurance – as Section 1 of the bill states:

> Prior approval for medical services . . . refers to ***health insurer*** requirements that certain physician-ordered treatments or services must be approved in advance by the insurer . . . before the insurer will provide final reimbursement or payment . . .

Disability income insurance provides cash payments designed to help individuals meet ongoing living expenses in the event they are unable to work due to illness or injury. *Unlike health insurance, disability income insurance does not provide coverage for the insured's health care or medical treatment*; further, *the cash payments are made directly to the insured – not to the insured's health care providers or suppliers*. Finally, *the disability income insurance policy* typically *does not dictate how the cash payments received by the insured are to be used* by the insured.

Consistent with the bill's stated purpose as set forth in Section 1 of the bill ACLI suggests that the new section proposed to be added to §431: 10A (beginning at line 11, page 2 of the bill) be amended to dispel any confusion that disability insurers are subject to the bill's provisions as set forth below:

> "§431:10A-____ Preauthorization; undue delay; liability. (a) ~~Notwithstanding any provision of the law to the contrary, n~~No insurer *referenced in this Section* that provides health care coverage shall require preauthorization of medical services or treatments so as to cause an undue delay in a patient's receipt of medical treatment or services.

Similarly, Section 3 of HB 885, HD 1, seeks to amend HRS Chapter 432, which includes not only Mutual Benefit Societies but also Fraternal Benefit Societies, by adding a new section. As in Section 2 of the Bill, this new section would prohibit *all insurers* governed by HRS Chapter 432 from requiring its preauthorization of medical services or treatments "so as to cause an undue delay" in the insured's receiving medical treatment or services. For violation, the insurer is made liable for the insured's injury caused by the undue delay in receiving medical treatment.

Several Fraternal Benefit Societies are ACLI member companies.

Chapter 432 authorizes Fraternal Benefit Societies to provide contractual benefits described in §432: 2-401, HRS, including disability income benefits, and such other benefits as authorized for life insurers.

Like Section 2 of HB 885, HD 1, the proposed provisions in Section 3 of the Bill are intended to apply only to health insurers – not Fraternal Benefit Societies issuing disability income insurance.

In order to dispel any confusion that a Fraternal Benefit Society issuing a disability income insurance policy is subject to the bill's provisions, ACLI suggests that the new section proposed to be added to Chapter 432 (beginning at line 16, page 4 of the bill) be amended as set forth below:

> "§432-____ Preauthorization; undue delay; liability. (a) ~~Notwithstanding any provision of the law to the contrary, n~~No insurer *referenced in this Section* that provides health care coverage shall require preauthorization of medical services or treatments so as to cause an undue delay in a patient's receipt of medical treatment or services.

Again, thank you for the opportunity to comment on HB 885, HD 1, Relating to Delay in Prior Approval for Medical Services.

LAW OFFICES OF
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A Limited Liability Law Company

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HB-885-HD-1
Submitted on: 2/22/2018 10:44:43 AM
Testimony for FIN on 2/23/2018 11:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Melodie Aduja	OCC Legislative Priorities Committee, Democratic Party of Hawai'i	Support	No

Comments:

HAWAII CHAPTER – AMERICAN PHYSICAL THERAPY ASSOCIATION

(800) 554-5569 x13 • www.hapta.org • info@hapta.org

HB885hd1, Relating to Delay in Prior Approval for Medical Services
FIN Committee Hearing
Friday, Feb. 23, 2018 – 11:00 am
Room 308
Position: Support

Chair Luke and Members of the House FIN Committee:
I am Gregg Pacilio, PT and Board President of the Hawaii Chapter of the American Physical Therapy Association (HAPTA), a non-profit professional organization serving more than 340 member Physical Therapists and Physical Therapist Assistants. Our members are employed in hospitals and health care facilities, the Department of Education school system, and private practice. We are movement specialists and are part of the spectrum of care for Hawaii, and provide rehabilitative services for infants and children, youth, adults and the elderly. Rehabilitative services are a vital part of restoring optimum functioning from neuromusculoskeletal injuries and impairments.

HAPTA **supports** the purpose of this measure that would prohibit insurers from requiring preauthorization that causes undue delay in a patient's receipt of medical treatment or services and clarifies insurer and licensed health care provider liability for patient injuries that are caused by preauthorization delays.

It is our experience that prior authorizations are an administrative burden for providers and appears to be arbitrary. For example, some insurance companies require physical therapy to be approved prior to start of care when objective measurements and functional outcomes are not being considered at all. Insurance companies also require physical therapists to pre-authorize procedure codes, which make the therapist "guess" what they are going to do and if you don't "guess" correct and request enough procedural codes, you may not get them paid on the back end. Further, insurance companies can take up to two weeks to render a decision on authorization request. During this time, the patient is waiting to be seen.

In addition to delaying care for patients, preauthorization requirements limit access to care because some providers have stopped taking insurances that require extensive pre-authorization paperwork.

Your support of HB885hd1 is appreciated. Thank you for the opportunity to testify. Please feel free to contact Patti Taira-Tokuuke, HAPTA's Reimbursement Issue Lead at (808) 895-1259 for further information.

HAWAII RADIOLOGICAL SOCIETY

LETTER OF SUPPORT

February 21, 2018

The Honorable Sylvia Luke, Chair
The Honorable Ty Cullen, Vice Chair
House Committee on Finance

RE: HB 885 HD 1

Dear Chair Luke, Vice Chair Cullen and Finance Committee members:

WITH REGARD TO **HB 885** which would prohibit health insurance preauthorization requirements that cause undue delay in receipt of medical treatment or services,

the Hawaii Radiological Society (HRS) supports this measure.

The prior authorization that is required by insurers for medical services causes lengthy delays in essential critical diagnostic studies, particularly when advanced imaging is requested such as MRI or CT scan. These prior authorization processes frequently obstruct the patient's access to necessary imaging in a timely fashion, effectively stalling the work up and preventing the prompt delivery of appropriate medical therapy.

HRS further supports quality initiatives of Hawaii physician groups as effective alternative solutions to improve efficiency, promote appropriate utilization of services, and maintain the highest standards of care for Hawaii's patient ohana.

Please contact us with any concerns or questions.
Mahalo for your thoughtful consideration of these issues.

With Aloha,

Elizabeth Ann Ignacio MD
President, Hawaii Radiological Society
808.250.7058

HB-885-HD-1
Submitted on: 2/21/2018 1:27:11 PM
Testimony for FIN on 2/23/2018 11:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
William Wong	Hawaii Vision Clinic	Support	No

Comments:

Dear Representatives,

Insurance companies are increasingly adding burdens to medical practices, with required prior authorizations, performance and quality measures, and technology costs. None of these burdens are compensated or reimbursed, nor are they designed to improve patient care. By requiring pre-authorizations for medications, treatment, and procedures, the insurance companies are by default influencing providers on how to practice medicine. At times, this negative influence can result in progression of disease, irreversible harm, and death by delay of care. It is now critical that these organizations be held liable if such delays and denial of care results in poor outcomes for our patients. Accountability needs to be placed on those responsible for the outcomes. Passing HB 885 would send a clear message to such entities that the practice of medicine is the responsibiltiy of the physicians, not the insurance companies, and their interference or obstruction of such care can bear serious consequences for our patients. Thank you for your time and consideration.

William K. Wong, Jr. MD

President, Hawaii Medical Association

Past President, Honolulu County Medical Society

Past President, Hawaii Ophthalmological Society

HB-885-HD-1
Submitted on: 2/22/2018 2:34:27 PM
Testimony for FIN on 2/23/2018 11:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Scott Grosskreutz, M.D.	Hawaii Radiological Society	Support	No

Comments:

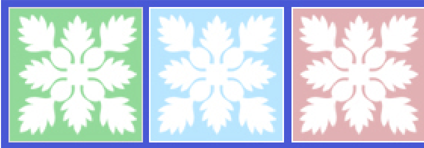
The Big Island is experiencing a critical shortage of health care providers and many patients are unable to obtain health care in a timely manner. Burdensome preauthorization requirements can delay patient care and severely limit the number of patients that providers can care for. One recent study estimated that it can take a health care provider's office up to 20 hours a week just to deal with preauthorization requirements.

The Federal Government has established the use of national medical appropriate use criteria, such as the American College of Radiology ACR Select to determine whether advanced imaging studies are medically appropriate for Medicare patients. These ACR criteria can be used to determine whether imaging studies are appropriate within minutes. Hilo Medical Center is integrating the ACR Select software into the hospital EMR at this time to enable all ordered studies to be immediately screened. The Hawaii Radiological Society and the Hawaii Medical Association support these appropriateness use criteria for screening patients in the Stae of Hawaii.

This bill wisely adopts the federal standard of care for determining the medical appropriateness, which would avoid delays in care which could harm patients, and enable providers to care for many more patients.

I strongly support this bill.

Scott Grosskreutz, M.D.



February 23, 2018

COMMITTEE ON FINANCE
Representative Sylvia Luke, Chair
Representative Ty J.K. Cullen, Vice Chair

House Bill 885 HD1 – Relating to Delay in Prior Approval for Medical Services

Chair, Vice Chair and Members of the Committees:

The Hawai'i Association of Health Plans (HAHP) respectfully submits testimony in opposition to HB 885 HD1. HAHP has significant concerns with HB 885 in terms of its impact on the quality and cost of health care in Hawai'i as follows:

1. Many of Hawaii's health plans have State and Federal programs that require the health plan to have medical management processes including preauthorization. In addition, such government programs as well as accrediting agencies (such as NCQA and URAC) provide external oversight and monitoring to ensure effective and responsive preauthorization processes by the health plans.

2. HB 855 inappropriately removes the provider from any liability as it relates to preauthorization. This does not take into consideration situations where the provider may have contributed to any delay in a patient receiving medically necessary and appropriate treatment.

3. HB 855 is not necessary as in situations where a health plan has in fact been shown to "cause undue delay in receipt of medical treatment or services" there are existing legal courses of action and remedies for any party adversely impacted.

In summary, HAHP does not support HB 885 HD1. While health plans recognize that some providers can be frustrated with preauthorization requirements, we believe there are alternative avenues to address this issue, primarily through provider and health plans communicating and collaborating with each other. In addition, health plans are already held accountable to standards on preauthorization processes by governmental agencies and accrediting entities such as NCQA, URAC and HSAG.

Sincerely,

HAHP Public Policy Committee
Cc: HAHP Board Members

UHA
HEALTH INSURANCE *Better Health • Better Life*

February 22, 2018

The Honorable Sylvia Luke, Chair
The Honorable Ty J.K. Cullen, Vice Chair
House Committee on Finance

Re: HB 885 HD1 – Relating to the Delay in Prior Approval for Medical Services

Dear Chair Luke, Vice Chair Cullen, and Committee Members:

University Health Alliance (UHA) appreciates the opportunity to testify on HB 885. The Bill prohibits health insurance preauthorization requirements that cause undue delay in receipt of medical treatment or services, and specifies that health plans, but not health care providers, are liable for civil damages caused by undue delays for preauthorization. UHA opposes HB 885.

The reasons for UHA's opposition are as follows:

1. Like all managed care plans in Hawaii, UHA has national accreditation status. UHA is accredited through URAC (the Utilization Review Accreditation Commission), which promotes continuous improvement in the quality and efficiency of healthcare management. URAC has specific guidelines and metrics for prior authorizations including approval/denial processes and specific turnaround times. For example, UHA follows the urgent preauthorization process under URAC that requires UHA to respond within 72 hours to the request.

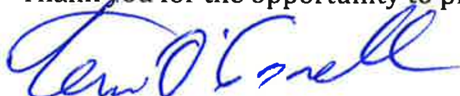
2. HB 885 would encourage less preauthorization. This would result in higher health care costs without a corresponding improvement in health outcomes. Members might receive services that are not necessary and could cause harm, which is what preauthorization prevents.

3. Section 1 of the Bill indicates an issue with preauthorization for advanced imaging studies. This bill is excessive in its expansiveness in that it applies to all preauthorizations. UHA is unaware of any issues with its preauthorization process.

4. Similarly excessive is holding a health plan solely responsible for the defense and indemnification of a health care provider for undue delay of preauthorization. The Bill does not take into account how the provider may have contributed to any delay.

We respectfully request the Committee defer HB 885.

Thank you for the opportunity to present this testimony.



Sincerely,
Terri O'Connell
Vice-President, Legal

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uhahealth.com

February 23, 2018
11:00 a.m.
Conference Room 308

The Honorable Sylvia Luke, Chair
The Honorable Ty J.K. Cullen, Vice Chair
House Committee on Finance

Re: HB885 HD1 Relating to Delay in Prior Approval for Medical Services

AlohaCare appreciates the opportunity to testify on HB885 HD1, which prohibits health insurance preauthorization requirements that cause undue delay in receipt of medical treatment or services and specifies that insurers, but not health care providers, are liable for civil damages caused by undue delays for preauthorization.

AlohaCare respectfully **opposes** HB885 HD1.

AlohaCare is a non-profit Hawaii based health plan founded in 1994 by Hawaii's community health centers. We serve Medicaid and Medicare Special Needs beneficiaries in all counties.

We believe that good health starts with timely, quality preventive care. AlohaCare encourages an open dialogue with our providers and we are committed to helping our members receive the care they need.

The medical request for preauthorization and notification are important processes in the coordination of care. Preauthorization ensures that only medically necessary and appropriate services are covered. Because the Medicaid program receives state and federal funding, we believe the preauthorization process is warranted to protect taxpayer dollars.

The QUEST Integration (QI) health plans are accredited through the National Committee for Quality Assurance (NCQA). As required by our State of Hawaii QI contracts, there are provisions that outline timeframes we must respond to regarding preauthorization, utilization management programs, and access standards for emergent, urgent and other care.

Current NCQA utilization management standards are 15 calendar days of receipt of the request for non-urgent pre-service decisions. AlohaCare currently practices existing

Med-QUEST Division (MQD) requirements of 14 calendar days for standard authorization decisions, and three business days for expedited requests.

For emergent and urgent services, under existing MQD requirements and current AlohaCare practices, a preauthorization is not required.

The complexity of a given medical condition and the physician's actions or inaction before placing a preauthorization request may make it difficult to determine that a preauthorization delay caused the patient's injury. Yet, HB885 HD1 seeks to make insurers *automatically* liable.

Each case is unique and turns on its own set of facts, and it should be evaluated in the medical malpractice arena accordingly. This bill assumes that all delays in the authorization process are caused by the insurance carriers and that the insurance carriers should bear the burden of proving the negative.

The proposed bill requires the insurer to indemnify and defend the doctor against a claim of undue delay when the doctor may have contributed to it. Seldom would a malpractice case be based solely on such a claim. It is more likely that undue delay, if raised, would be one of several claims in a case involving patient harm.

This bill could incentivize doctors to circumvent the process by deciding not to wait for a response from the insurance carrier knowing that if their judgment is later questioned, it is up to the insurance carrier to prove that they did not have a "reasonable belief" in their decision. This places the insurance carrier in the impossible position of proving what the doctor was thinking. Doctors would have no incentive to use caution in such decisions.

AlohaCare believes in and supports the role of the primary care physician (PCP). The PCP's responsibility is to both provide and coordinate care to ensure that members receive medically appropriate services.

AlohaCare recognizes that a successful partnership with our providers depends on acceptance of responsibility and a commitment to open, effective communication by both parties. We appreciate the willingness of the provider community to partner with us to assure access to quality care for the most disadvantaged members of our community.

Thank you for the opportunity to testify on this measure.

HB-885-HD-1
Submitted on: 2/21/2018 6:03:34 PM
Testimony for FIN on 2/23/2018 11:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Andrew Kayes, M.D.	Individual	Support	No

Comments:

While I support trying to limit health care costs, pre-authorization for doctors to order tests often causes a delay and individuals in practices must spend time working on the preauthorization rather than helping the patient. many well documented studies show this is "cost shifting" rather than "cost saving," putting a cost and burden on local physicians that is time consuming, costly for local practices and simply unecessary. It would be far more effective for insurance companies to educate outlier providers who order tests incorrectly and re-educate them rather than have the vast majority of doctors doing good clinical work have yet another hurdle to overcome to help their patients. The main insurers here in Hawaii have done the equivalent of "punishing the whole class" for a few bad outlyers' behavior. And if insurance companies insist upon having this in my mind unecessary hurdle, then they should share in the responsibility of any bad outcomes...only fair. Only pono for the people of Hawaii.

HB-885-HD-1
Submitted on: 2/21/2018 8:44:52 PM
Testimony for FIN on 2/23/2018 11:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Vivien	Individual	Support	No

Comments:

I strongly encourage a full support of this bill. As a radiologist, my primary goal is always to provide timely efficient imaging to our patients because a prompt diagnosis of a life altering disease is vital prior to obtaining life saving medical treatments. A decision to perform a particular examination should not be made by health insurance companies who have financial incentives to not perform examination but should be solely depended on the judgement of an experienced medical professional who has an intimate medical knowledge of the patient. If this patient to doctor relationship is jeopartized by the pre-authorization requirement of the insurance company, then harm caused by undue delay in medical treatment should rest solely on the health insurance company and not the health care provider.

HB-885-HD-1
Submitted on: 2/22/2018 12:02:28 AM
Testimony for FIN on 2/23/2018 11:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
John Culliney, MD	Individual	Support	No

Comments:

The Insurance Companies have too much control over medicine and sacrifices good medical care for profits. Please help to stop this madness. Please allow doctors to once again deliver appropriate care without being bullied by the large insurance companies. Mahalo.

HB-885-HD-1
Submitted on: 2/22/2018 9:15:08 AM
Testimony for FIN on 2/23/2018 11:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Carlton Yuen	Individual	Support	No

Comments:

If a doctor orders a necessary test, and that test is delayed or denied by an insurance plan, and that patient suffers as a result of this delay or deny, the physician should not be held liable for the patients injury as it pertains to the delay in treatment.

This bill is a common sense measure and should be enacted as soon as possible to ensure patient safety and encourage health plans approve appropriate care.

This bill has the following admirable goals:

1.) Prohibit insurers from requiring preauthorization that causes undue delay in a patient’s receipt of medical treatment or services; and

2.) Clarify liability for patient injuries caused by preauthorization delays.

It is only fair that a licensed health care provider should be immune from civil liability for injury to a patient that was caused by undue delay in preauthorization of medical treatment services. The insurer should be civilly liable for any injury that occurs to a patient because of undue delay in medical treatment.

Thank you for the opportunity to provide testimony in strong support of this measure and thank you for hearing this important bill. This bill will help to make Hawaii a more viable place to practice medicine.

Respectfully,

Carlton Yuen

HB-885-HD-1
Submitted on: 2/22/2018 2:01:20 PM
Testimony for FIN on 2/23/2018 11:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Cyndi Apana	Individual	Support	No

Comments:

I support this bill. If I were to need a procedure, I would like for authorization to be automatic or speedy. Please pass this bill and protect people. Mahalo. Cyndi

HB-885-HD-1
Submitted on: 2/22/2018 9:54:25 PM
Testimony for FIN on 2/23/2018 11:00:00 AM

LATE

Submitted By	Organization	Testifier Position	Present at Hearing
Nancy Chen	Individual	Support	No

Comments:

Dear Legislators and Senators,

I am a practicing physician and would like you to know that I strongly support this bill.

If a doctor orders a necessary test, and that test is delayed or denied by an insurance plan, and that patient suffers as a result of this delay or deny, the physician should not be held liable for the patients injury as it pertains to the delay in treatment.

This bill is a common sense measure and should be enacted as soon as possible to ensure patient safety and encourage health plans approve appropriate care.

This bill has the following admirable goals:

1) prohibit insurers from requiring preauthorization that causes undue delay in a patient's receipt of medical treatment or services; and

2) clarify liability for patient injuries caused by preauthorization delays

It is only fair that a licensed health care provider should be immune from civil liability for injury to a patient that was caused by undue delay in preauthorization of medical treatment services. The insurer should be civilly liable for any injury that occurs to a patient because of undue delay in medical treatment.

Example of delay in care: 56 yo male referred by PCP for double vision for the past 2 days. On examination, he was found to have severe proptosis and decrease in eye movement in all directions. It was a Friday morning, we requested a MRI to rule out possible mass compression of the globe and we were denied same day. We were told to send the patient to the ER if he we wanted to get the MRI done. The cost for sending the patient to the ER for unecessary reason doubled because of that and the insurance did not save any money by denying the initial MRI requested.

Thank you for your attention to this matter, remember we will all be patients one day. One day we may fall victim of the insurance process, think about your family, your aging parents, your friends. I would like to show my strong support to this bill via this letter and if you have any questions, please feel free to contact me at any time.

Sincerely yours,

Nancy Chen, MD